CELSUS ACADEMIE VOOR BETAALBARE ZORG

Impact of multiple payer purchasing on ‘triple aim’ healthcare. Experiences of the Dutch market reforms

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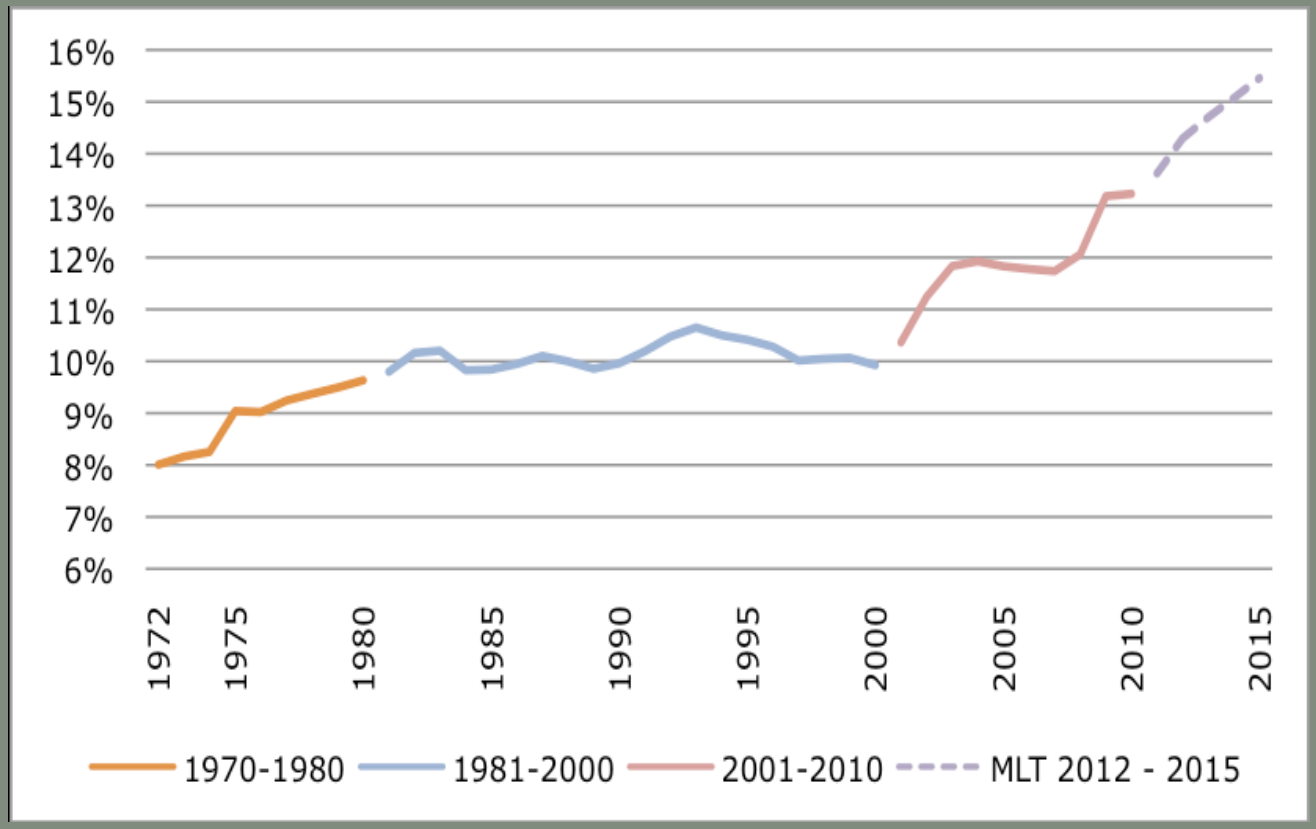
Three questions

- ‘Market-based’ health care. What typifies the Dutch style?
- Is multiple-payer competition congruent with current challenges? Looking above the water and underneath the surface.
- Being at ‘risk’ to value-for-money: inducing ‘all’ to accomplish the ‘triple aim’ ?

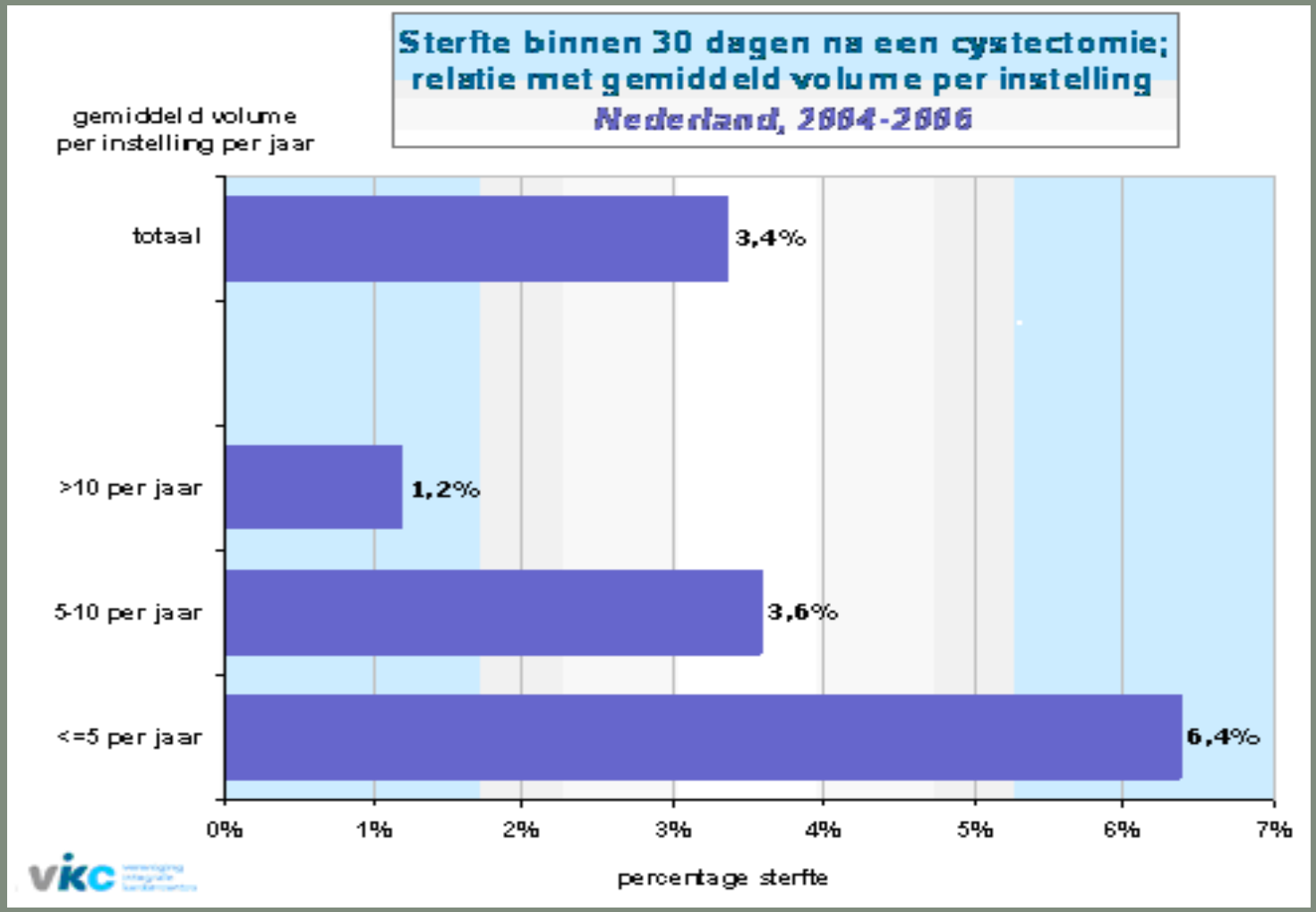
Critical junctures in health expenditure



‘Triple aim’ in the Netherlands?

- High variety of quality and spending intensity without clear a association
- Ending the ‘veil-of-ignorance’ on quality:
  1) prescription following guidelines: 50 - 80%;
  2) unplanned cesearean sections: 7 - 30%;
  3) mental health dropouts: 5 – 30%;
  4) hospital infections: 1 – 10%;
  5) hospital variety in mortality: in bladder cancer up to 500%, and in colon cancer up to 300%
- High physician remunerations
- Low utility rates (65%), but capital costs (13%) almost double OECD average

Variety in hospital mortality: bladder cancer



Implementation ‘triple aim’ notoriously difficult

- Best practices which combine low costs / high quality do not spread (VA, Kaiser, BSBC Mass, Geisinger, Grand Junction, Maccabi Health, Alzira, etc.)

- High ‘political’ transaction costs:
  1) requiring ‘non-negotiable’ implementation elements crucial
  2) ‘high-penalty’ like closing hospitals often not feasible option
  3) negotiating institutions more ‘difficult’ than negotiating budgets

- Current pay-for-performance strategies lack leverage

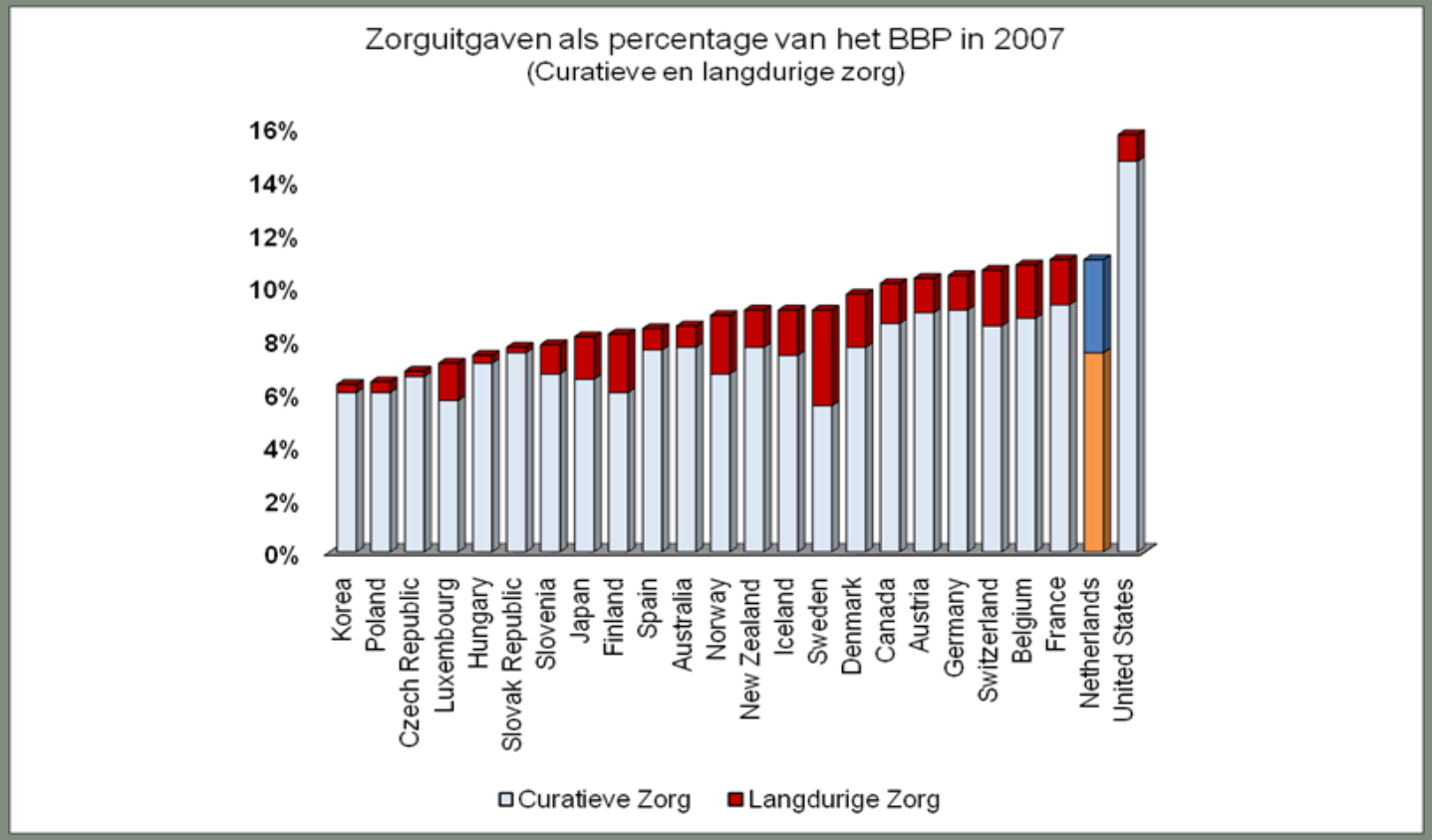
- Providers / insurers always suspicious for ‘working harder for less money’

- Quality-of-care still a missing metric in many institutional solutions

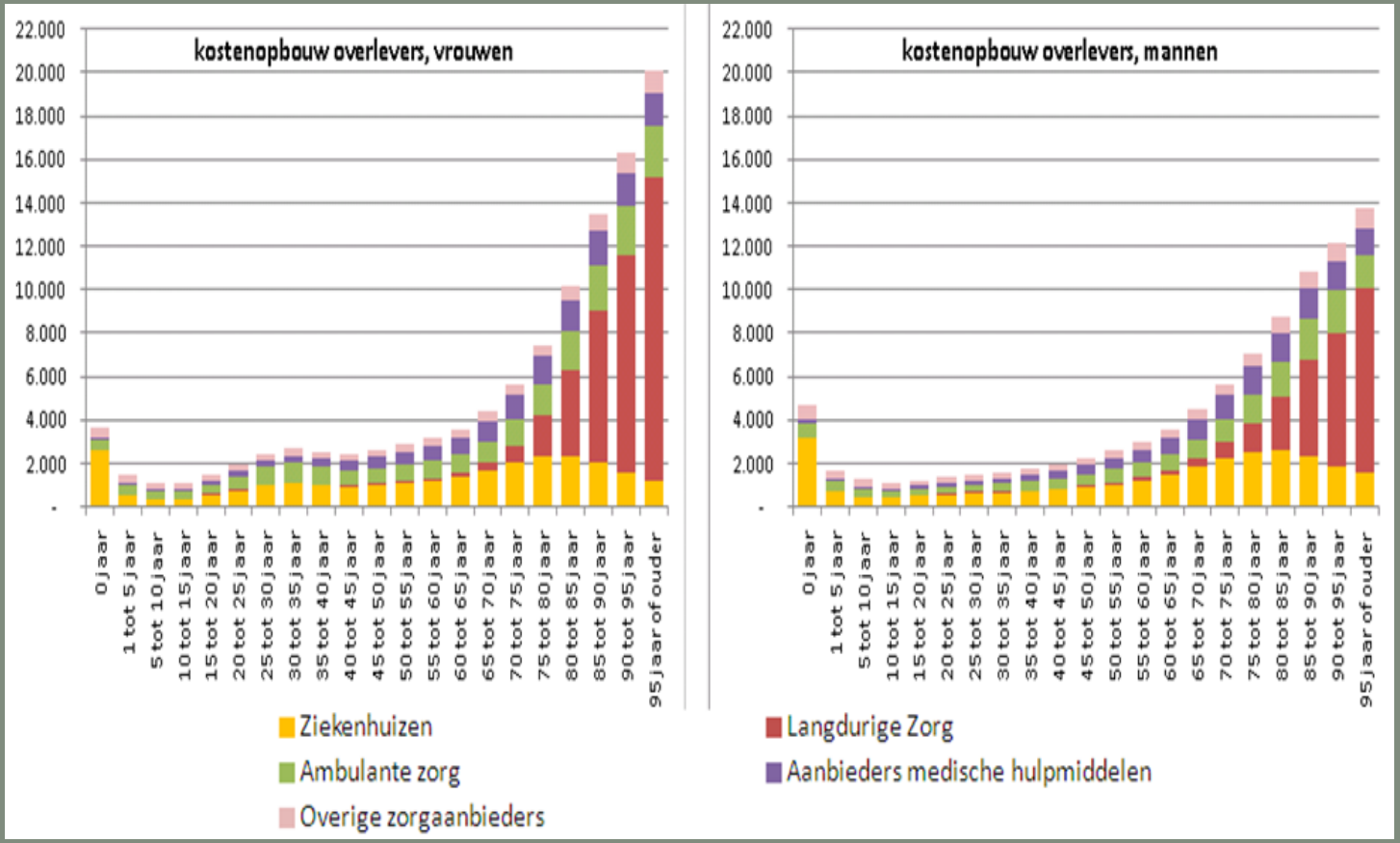
Understanding Dutch healthcare: institutional constraints that withstood the test of time

- Maximizing risk-solidarity, (e.g. 'low' out-of-pocket expenses; broad and deep benefit basket; community-rating; risk-adjustment; few differences in health outcomes)
- Gatekeeper is the family physician (also increases risk-solidarity)
- Stewardship: tradition of negotiating, mediating, and co-governing with the major interest groups (polder model)
- Large general acute-care **nonprofit** hospitals; care is normally 'around-the-corner'
- Average acute health care sector; large long-term care sector
- Underlying institutional logics support low volume, high price acute healthcare

Average acute care; large LTC sector (% GDP) 2007)



Fiscal ‘sustainability’s main challenge: LTC



'Tale one': A new market, but with…

More not less solidarity

- ❑ Open enrolment & community rating
- ❑ Risk adjustment (induces a narrow premium range)
- ❑ Health care allowance (tax credit) & free care children
- ❑ Initial low compulsory deductible (€ 165 in 2006; € 350 in 2013)

Embedded in stable political and professional governance

- ❑ Stewardship: co-governing with major interest groups (polder model)
- ❑ Global budget (increasingly without enforcement)
- ❑ Navigation through professionals, not through payers

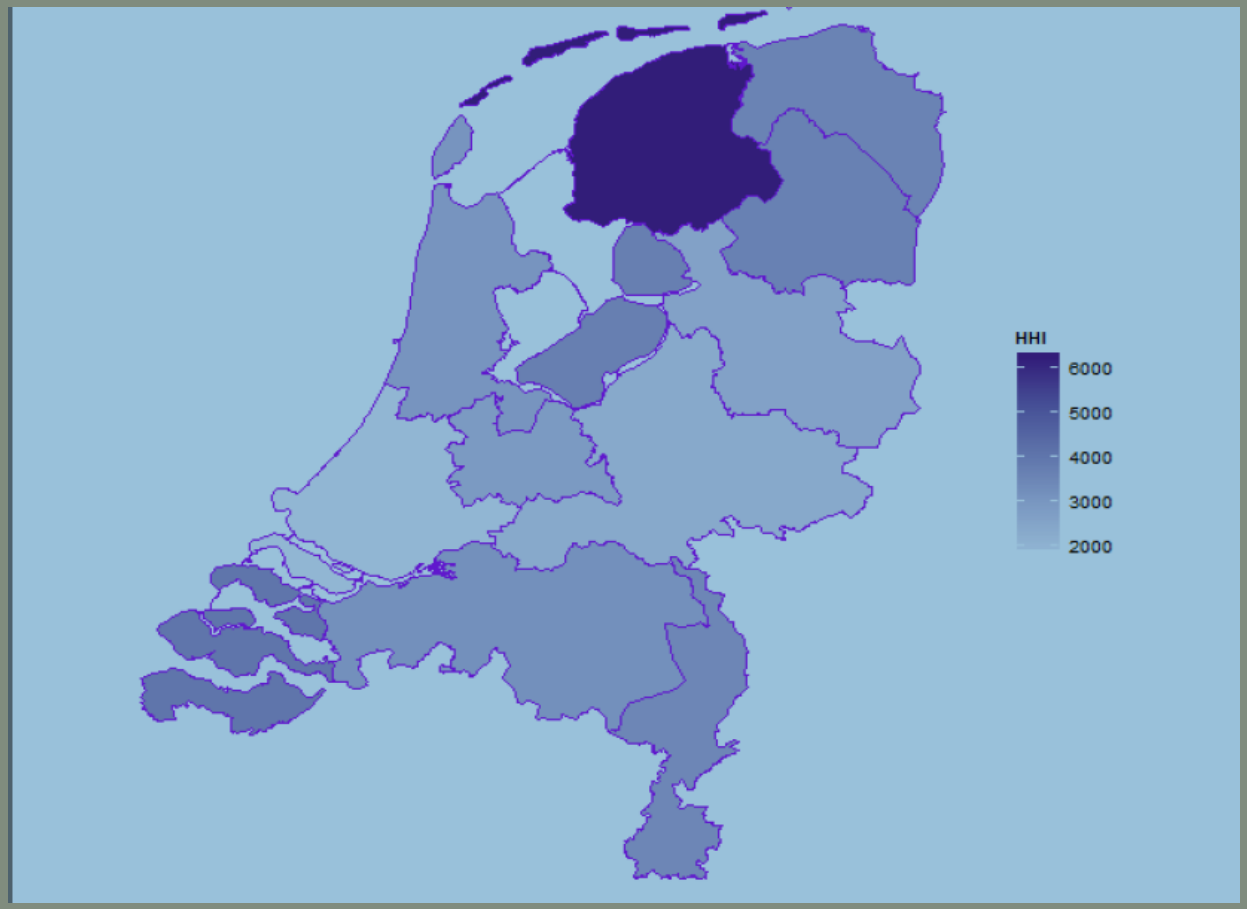
Insurers and providers got more discretionary powers, but without 'risk'

- ❑ New safety nets imply that risks decreased: DTCs, (volume) overruns
- ❑ Discretionary powers: liberated provider prices and network contracting

‘Tale one’: business as usual

- Switching insurance policies, but only once (2006: 19%)
- No changes in trend of (rapid) cost inflation (5-6%)
- Mergers between insurers: 9 left and top 4 holds 93% market-share
- Few selective contracting & network policies
- Episode payment experiments (DM) does not seem to reduce costs
- Volume growth in excess of epidemiological trend (no waiting lists)

Health purchasing, a concentrated market - especially in rural areas (HHI > 2.000)



‘Tale two’: beneath the surface of multiple-payer competition

- Changed mental model: much ‘entrepreneurship’ on the boundaries

  Inducing provider diversity: disease-management, 24-7 primary care clinics, fast track surgery, outpatient centres, insurers start provider organizations, contracting medical tourism

- Pricing pressure generics, pharmaceutical services & elective surgery; moderate growth expenses outlier patients

- Strong growth (hospital) productivity (3%); productivity pharmacies (9%)

- Increasing solvency levels: providers & insurers (now at 20%)

- Increasing claims ratio and declining administrative expenses

- Declining numbers uninsured: 194.000 (2009); 40.000 (2012)

‘Tale two’: beneath the surface of multiple-payer competition

- Finally at ‘risk’: ending safety net (volume) overruns; decreasing ex post risk corrections; 70% prices freely negotiable
- Selective contracting: volume thresholds cancer care; pharmaceutical services, capitation experiments, ACO (Parkinsonnet)
- Choosing ‘risk’: patients and enrollees
- Flat growth or slightly declining 2013/2014 premiums
- Adding corporatist governance and no overruns in 2013 …

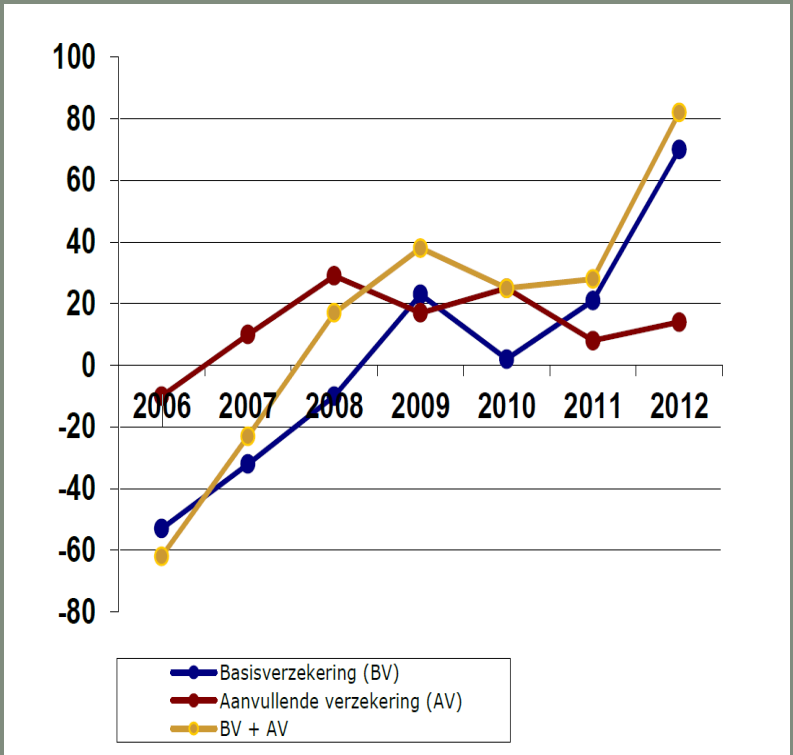
Administrative costs; switching; group contracts

	2006	2008	2010	2011	2012	2013
Admin. costs obligatory insurance	4.5%	3.7%	2.9%	3.0%	2.9%	
Admin. costs suppl. Insurance	13.4%	12.6%	13%	12.4%	11.3%	
Switching	19%	3.6%	3.9%	5.4%	6.0%	8.3%
Group contracts	55%	59%	64%	66%	68%	69%

Administrative costs of hospitals

	Core	Total	% GDP
US	15.51%	25.32%	1.43
Netherlands	10.85%	19.79%	0.77
Canada	7.40%	12.42%	0.41
France	8.77%	n/a	n/a
Germany	9.00%	n/a	n/a
England	n/a	15.45%	n/a
Scotland	n/a	11.59%	0.51
Wales	n/a	14.27%	0.66

Increasing margins, increasing solvency

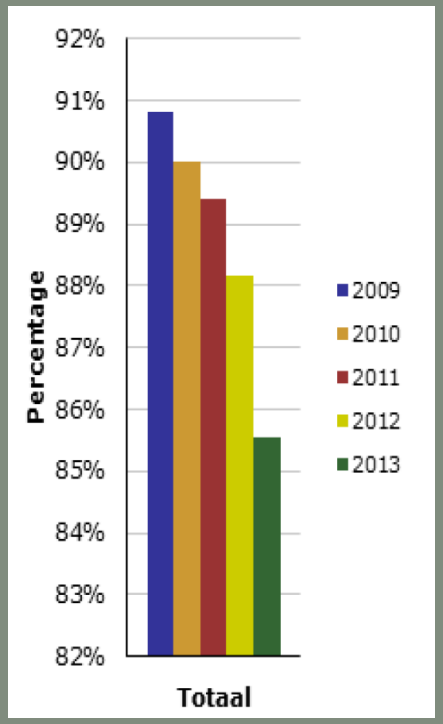


Margin per enrollee (€)

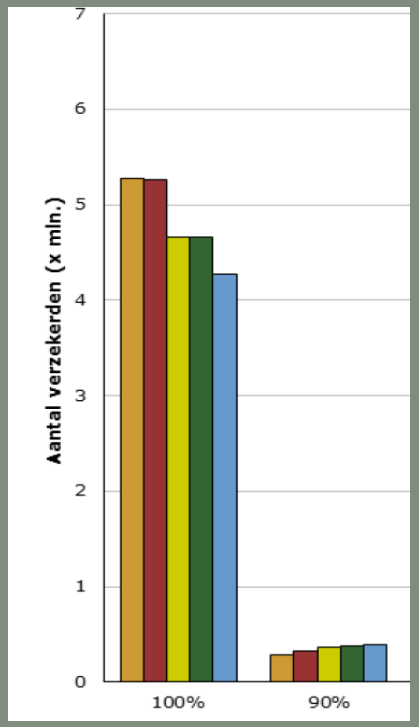
Margin %		Solvency %	
2004	2011	2004	2011
1.9	3.1	9.1	15.4

Hospitals (%)

Choosing more ‘risk’: patients and enrolees



Supplementary insurance



full insurance

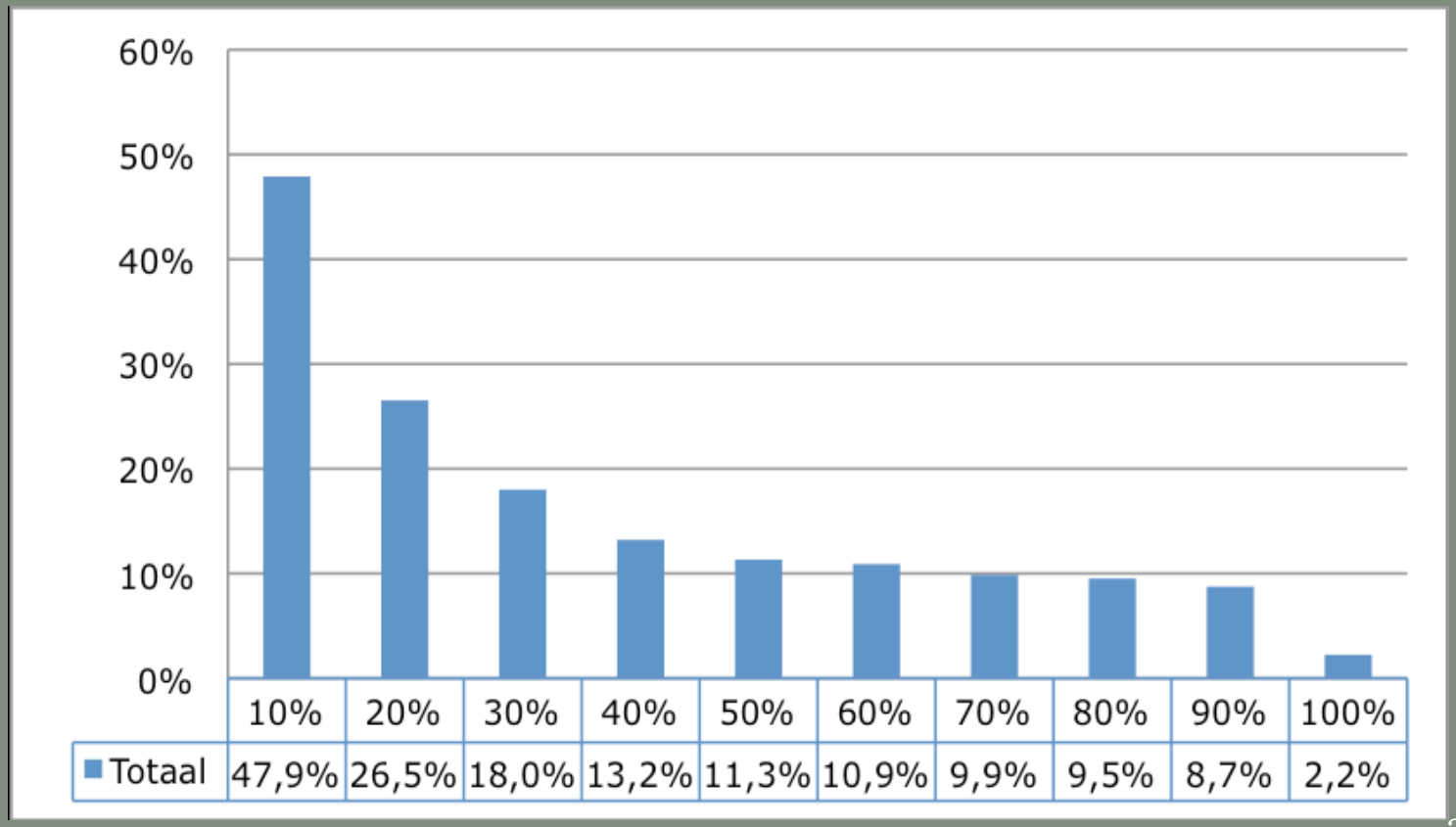
Vrijwillig eigen risico categorie	2009	2010	2011	2012	2013
Geen vrijwillig eigen risico	94,9%	94,7%	94,0%	93,1%	90,3%
€ 100	1,5%	1,5%	1,4%	1,4%	1,4%
€ 200	0,8%	0,9%	0,9%	0,9%	1,1%
€ 300	0,6%	0,6%	0,8%	0,9%	0,7%
€ 400	0,2%	0,1%	0,1%	0,1%	0,2%
€ 500	2,0%	2,2%	2,7%	3,6%	6,2%

Voluntary deductable

Insurers: increasing utilization reviews

Aanspraak	Natura	Toegangseisen	Toestemming	Voorschrift	Verwijzing
Ambulance vervoer	51%	60%	40%	34%	9%
Dieetadvisering	48%	76%	3%	0%	70%
Ergotherapie	51%	67%	0%	21%	43%
Farmaceutische zorg	51%	100%	46%	90%	0%
Fysiotherapie	52%	87%	37%	21%	79%
GGZ	51%	96%	1%	6%	96%
Huisartsenzorg	61%	22%	15%	0%	10%
Hulpmiddelenzorg	54%	93%	58%	9%	24%
Ketenzorg	64%	29%	6%	0%	23%
Kraamzorg	54%	54%	1%	6%	18%
Logopedie	51%	72%	0%	21%	48%
Med. Spec. zorg	52%	100%	66%	0%	97%
Mondzorg	52%	97%	76%	0%	52%
Oefentherapie	52%	84%	37%	21%	78%
Verloskundige zorg	52%	36%	3%	6%	30%
Zittend ziekenvervoer	52%	100%	79%	36%	4%
Overige vormen	38%	8%	8%	0%	8%

Substitution towards lower case costs & increase less complex volume (2006 – 2008)



Governmental forecasts too pessimistic? Differences between forecasted and actual average health premium (€ per enrollee)

	2006	2007	2008	2009	2010	2011
Forecast	851	879	1057	1074	1085	1211
Actual	771	848	1050	1064	1110	1210
Difference	-78	-31	-7	-10	25	-1

The ‘solution’: doing all that is reasonable

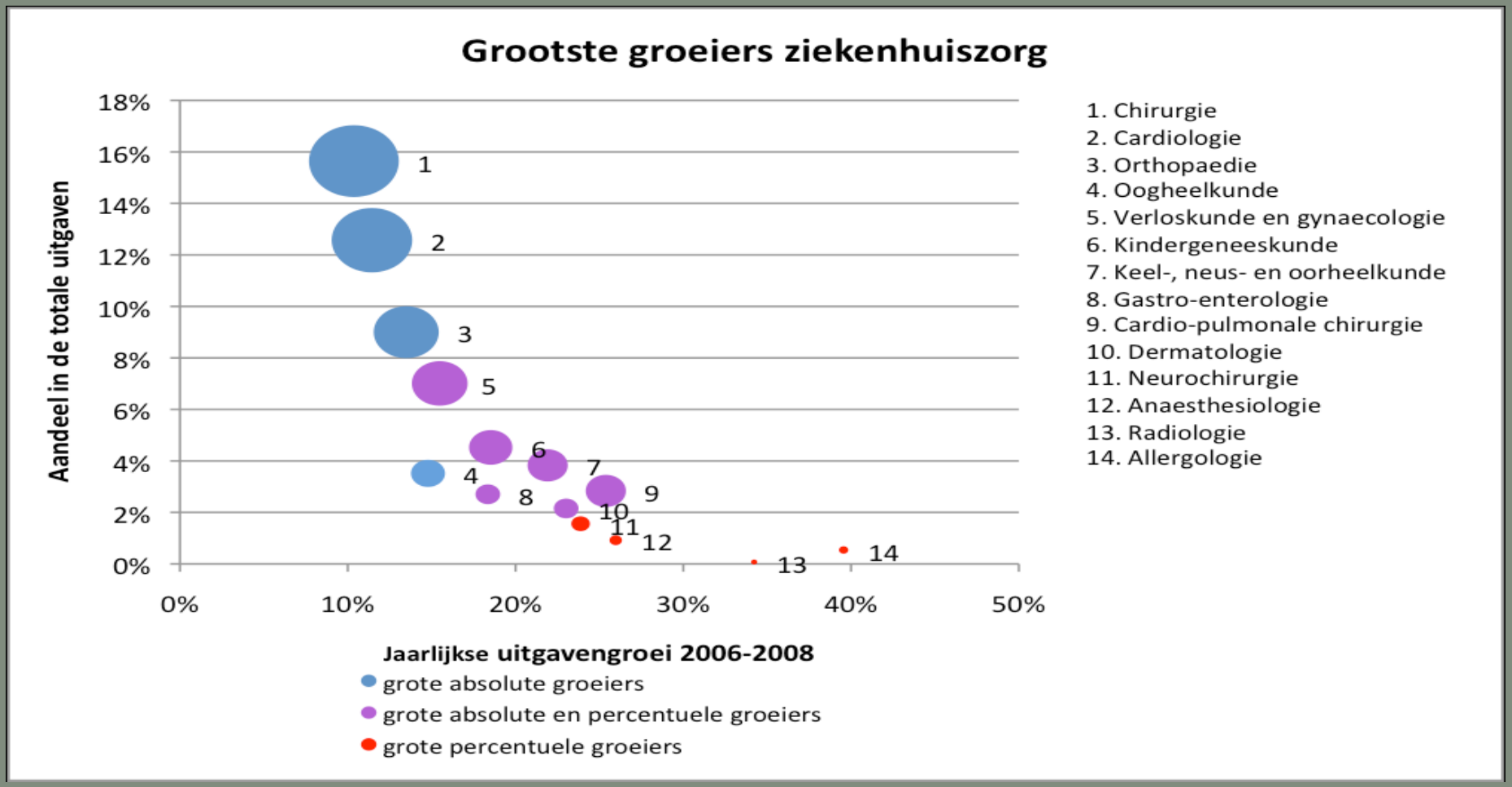
- Increasing ’risk’ for agencies & providers & insurers & patients etc.
- ‘Risk’ induces dynamism by combination of adoptive and innovative strategies – flexiile contracts essential facilitator
- But how to balance ‘positive’ and ‘negative’ risks?
- Increasing institutional efficiency
  1. governance
  2. reimbursement
  3. scope of the benefit package
  4. out-of-pocket payments
  5. comparative effectiveness research & HTA etc.

need to reinforce each other to ’punish’ non-appropriate care.

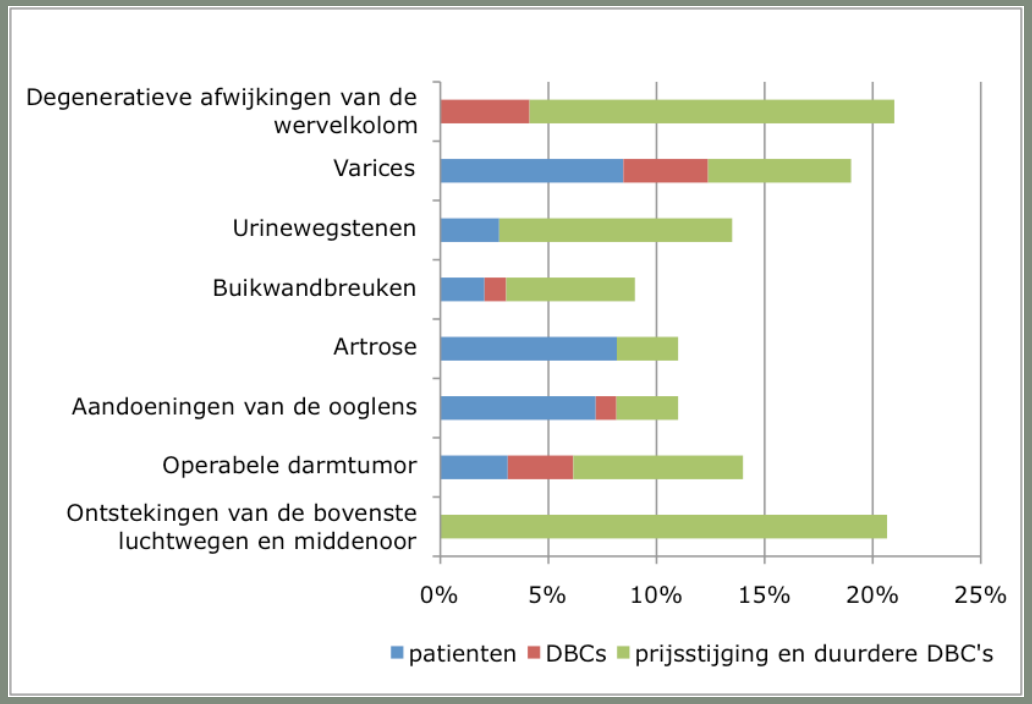
- Learning-by-doing essential to create a workable mix …

Thank you for your attention

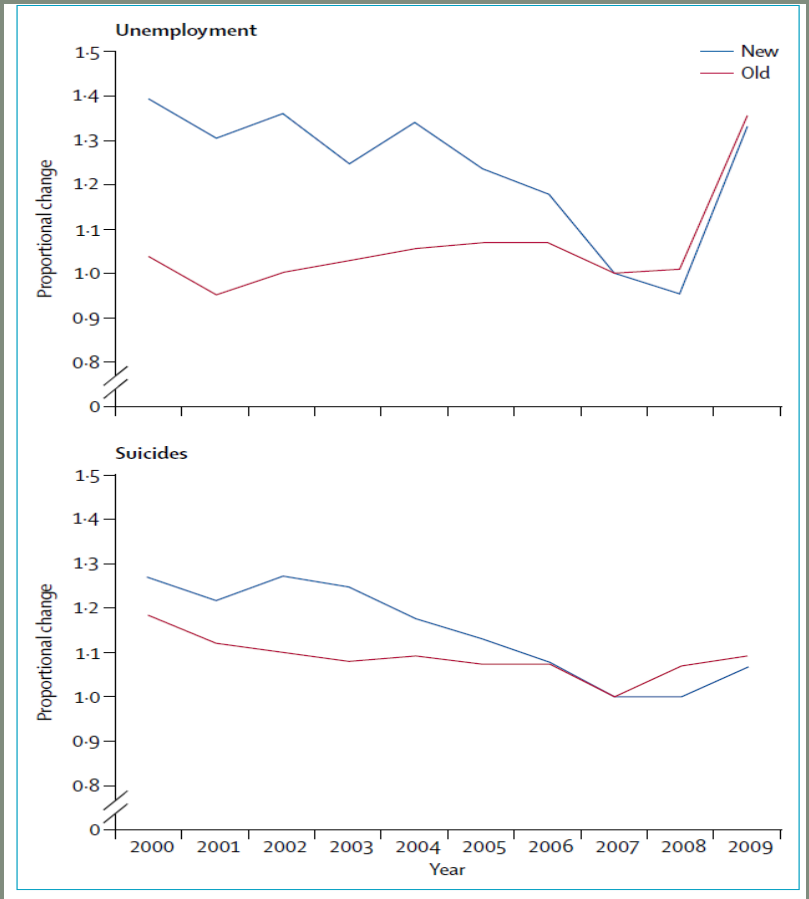
Questions / comments pp.jeurissen@minvws.nl


Grootste groeiers ziekenhuiszorg
Aandeel in de totale uitgaven
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
0%
10%
20%
30%
40%
50%
1
2
3
5
6
4
7
8
9
10
11
12
13
14
Jaarlijkse uitgavengroei 2006-2008
grote absolute groeiers
grote absolute en percentuele groeiers
grote percentuele groeiers
1. Chirurgie
2. Cardiologie
3. Orthopaedie
4. Oogheelkunde
5. Verloskunde en gynaecologie
6. Kindergeneeskunde
7. Keel-, neus- en oorheelkunde
8. Gastro-enterologie
9. Cardio-pulmonale chirurgie
10. Dermatologie
11. Neurochirurgie
12. Anaesthesiologie
13. Radiologie
14. Allergologie

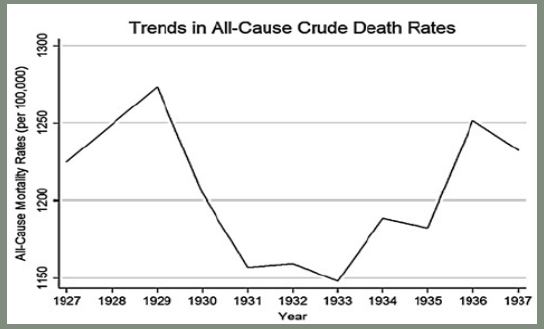
Price per case increases, mostly as a result of more expensive DTCs



Economic ‘depressions’ and health: what do we know?



Actually, 1931 was one of the healthiest years in the history of the country – The evidence is overwhelming – NewYork Times, January 5th, 1932



- ❑ **Positive association unemployment and suicide**
- ❑ **Negative association gdp-growth and traffic accidents**
- ❑ **Decline of demand ‘private’ healthcare**
- ❑ **Older unemployed die three years early (VS)**
- ❑ **Increase of healthy living (Iceland)**
- ❑ **Vulnarable groups worse off**
- ❑ **Strength of association depends on safety net**

Out-of-pocket payments: closing towards the middle-of-the-pack

	Overheid en sociale zekerheid	Particuliere verzekering	Huishoudens, out-of-pocket	Overig	Totaal
	%				
België	70,7	3,5	25,6	0,3	100
Australië	68,1	7,8	20,5	3,5	100
Zweden	80,1	0,0	19,9	0,0	100
Japan	80,2	2,2	17,5	0,0	100
Denemarken	81,8	2,2	16,0	0,0	100
Duitsland	78,0	10,1	11,6	0,3	100
Frankrijk	77,1	13,5	9,3	0,0	100
Nederland	82,9	7,8	8,0*	1,4	100

Bron: OECD Health Data 2012.

* Exclusief betalingen onder eigen risico.

Current cost-containment strategies

- Attacking ‘pharmaceuticals’ with tail wind from empty pipelines
- LTC: devolving community care to municipalities & reducing fee updates
- Acute care: ‘voluntary’ budget limitations (inducing capitation fees)
- Increasing co-pays with tail wind from recession (less demand)
- Retreating financial compensation chronically ill
- Reducing the benefit basket?